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EVALUATION
DATA FOR DECISION MAKING PROJECT
IN THE PHILIPPINES
EXECUTIVE SUMMARY

This report presents the overall end-of-project evaluation including the results of previous baseline and interim reports to assess the Data for Decision Making Project in the Philippines. The INCLIN-CEU Manila was contracted to undertake the external evaluation of the project with the following specific objectives: (1) to carry out interim evaluations giving feedback on the progress of project activities throughout implementation; (2) to assess the feasibility of meeting project goals and objectives as laid out in the DDM work and implementation plan, and (3) to assess the degree to which the project is achieving its goals and objectives.

Brief Project Background

The Data for Decision Making Project (DDM) in the Philippines is a collaboration between the Field Epidemiology Training Program of the Department of Health and the Centers for Disease Control (CDC) and the Harvard Consortium to the Philippines. The DDM was piloted in Region V (Bicol) and Cordillera Autonomous Region (CAR) with the following goals: (1) provide timely information to decision makers at central, regional, provincial, municipal levels of the public health system, and even to NGOs and institutions related to DOH; (2) provide applied epidemiology and management capacity of regional epidemiology unit staff to provide improved program management support and technical assistance to key local government unit (LGU) health officials, mayors and governors; (3) to demonstrate the increased use of information at different levels of the health system for:

- (a) setting health program priorities
- (b) planning and budgeting for public health programs
- (c) evaluating program effectiveness and impact
- (d) allocating current and available resources efficiently
- (e) advocating for public health resources

The DDM project interventions were grouped into four components: selecting indicators, establishing Regional Epidemiology and Surveillance Units (RESU), communications and management. It had seven operational objectives:

1. Identify and develop consensus on a selected number of indicators.
2. identify sources of data and data gaps.
3. Build capacity of two regional epidemiology and surveillance units.
4. Develop and test computer stations.
5. Develop and test formats for communicating data to targeted decision makers.
6. Build capacity of the RESU staff to provide technical assistance in applied epidemiology and management to LGU health officials and program managers.
7. Demonstrate use of indicators in a public health decision making process. Central and RESU will have worked with local government officials in using the indicators to solve health problems.

Evaluation Methodology

The evaluation team conducted site visits before, during, and after the interventions were in place; conducted out surveys, using questionnaires and interviews for the baseline status, two interim evaluations and final assessment. Analysis utilized descriptive statistics, qualitative analysis, content analysis, group process diagnosis and process documentation and case studies.

Evaluation Results

1. Implementing Activities and Interventions

The interventions were in place within the time frame of the project, except in the case of the management component which were deliberately delayed until after the May 1994 elections. These activities consisted mainly of training programs-workshops and installation of the computer stations and the structure of the RESU.

Generally, the implementing activities were favorably rated as having been handled quite well by the coordinators and facilitators. The learning objectives of the sessions and program as a whole were accomplished. The workshops-training programs increased knowledge, improved attitudes and developed skills in the participants. The computer programs increased the computer literacy of health workers and even of the data managers who already had exposure to computer systems, though not sufficiently beyond basic competencies. The management workshops for the Local Health Board members developed the capabilities particularly of the municipal, city and provincial health officers in health problem identification, prioritization, action planning. The communication interventions built into the management workshops developed their skills in advocacy, data presentation, inter-personal relations. The workshops gave local government officials some familiarity with data based decision making.

The main issue in the implementing activities pertains to the non-attendance of majority of the targeted decision makers, that is, the local government officials. Their lack of knowledge and attitudes of support and commitment on the DDM later showed up as a critical hindrance. There was no follow-up on them in between activities, to ensure that they had full familiarity about and support for the DDM.

Substantive and procedural weaknesses were identified. In the workshops to determine the set of consensus indicators, the time was too short and the process of consensus seeking so rapidly done. In the end, the selected DDM indicators reflected mostly the maternal child health program. Since they are indicators relatively of strong and active maternal programs, the local officials addressed their efforts to local problems which because of its geographic proximity seemed more urgent.

The action planning during the LHB workshops was accomplished as an exercise without consideration of its feasible use upon return to work. While DDM core indicators were selected in the action planning exercise, these were eventually set aside during the actual decision making processes of the LHB and replaced by local health problems and indicators.

2. Goals and Objectives Achieved

- 2.1 Objective 1. Ten (10)** National indicators were used for data collection, collation, analysis and interpretation. These became useful for monitoring and improving performance of the RHUs. Only a few LGUs used the DDM indicators in discussion for decision making by the Local Health Board: nutrition data, number of diarrheal cases, number of rabies cases, number of new toilets constructed, safe water, and the co-trimoxazole supply. For program intervention and budgeting, local health problems and indicators were preferred: salt iodization, blood bank, rabies, diarrhea, waste management.
- 2.2 Objective 2.** Sources of data were identified and are available for the indicators. LHBs made use of other qualitative data sources such as observation, "gut feelings", political demands, advice of political officials. Health officers were relied upon for data interpretation and presentation in understandable way to local officials. Computerization has made it easy to do data collation, analysis, storage and retrieval.
- 2.3 Objective 3.** The RESU personnel, 3 at Bicol and 5 at CAR had been trained in using the computer programs on EPI Info, EPI Map, and Harvard Graphics. They knew the 12 operational steps in data collection and processing and have positive feelings toward data collection. But the RESU's performance has been hindered by the transfer of trained staff and its understaffing, the dysfunctions and repairs of the computers, the slow dot matrix computers, the late submissions from the municipalities. The focus of the RESU has also been shifted because of the decision to focus on the LHB as the structure for health management.
- 2.4 Objective 4.** A detailed flow chart has been developed to guide the people in the BHS, health centers, provincial health offices, and RESU in data collection, collation and reporting of the data. The personnel still need time to be adept at the process. They expressed the need to develop more competencies in using the computer beyond the training they have received. despite the trainings. Delays in the flow have caused delays in the output.

- 2.5 Objective 5.** As a consequence of the DDM, the health officers developed better rapport with the members of the LHB and influenced decision making as they were consulted by local officials for health data analysis, interpretation, program planning. Their advocacy pushed the application of the DDM indicators and data based decision making, although the LHBs preferred to use local indicators. The DDM communication and advocacy strategies helped the health officers present data in an understandable way to local officials and developed better communication between and among health workers, between superiors and subordinates. However, health data are still not completely comprehensible to most of the local officials.
- 2.6 Objective 6.** The DDM facilitated the functioning of the Local Health Boards as meetings were convened, though not regularly. During the times that the LHBs had met, data based decision making occurred to the extent of using some of the DDM indicators and even when local data (not DDM indicators) were used. The health officers became instrumental in the utilization of the health management workshop learnings for health problem solving, intervention strategies, advocacy, and budgeting. Cases have been found showing that the LHBs used local data and a few DDM indicators for health program interventions and budget allocations (see objective 1).

The DDM became too dependent on the LHB though its functionality cannot be guaranteed because the mayors have not been convinced of the importance of the DDM and even the LHB. Majority of the mayors did not attend DDM workshops, a few who did were quite supportive. The LHBs have also been dysfunctional due to the discord between the mayor and the Sanggunian representative for political party differences or between the mayor and the health officer. Other venues were used by the mayor for decision making such as merely consulting with the health officer and by meetings with the departments.

The MHO, CHO, PHO became influential and provided technical assistance more than the RESU had been visible. The RESU's roles in providing the technical assistance in data based decision making, particularly in advocacy, have not clearly surfaced except for its functions in coordinating and facilitating the DDM workshops, linking with the LGUs for workshop attendance.

2.7 Objective 7. The post-intervention evaluation showed that health policy formulation has moved up to first priority and rank followed by other concerns as administration, livelihood, environment, etc. compared to its low priority before the DDM. Decisions have been based on health statistics despite the continued use of public opinion and electoral demands. The DDM indicators may not have been fully utilized but the DDM has become a perspective, a way of looking at health problems and decision making with the use of evidence.

The LHBs became functional with meetings ranging from at least 1 to an LGU with 7 by December 1995 and from 1-2 meetings from January to May 1996. Mayors now actively consult health officers who have used advocacy and developed better relations with the local officials as a consequence of the DDM training. The DDM management interventions have been used in the cases of data based decision making for salt iodization, purchase of medicines, toilets, blood bank, nutrition, waste management.

The comparison of LHBs in DDM and non-DDM areas showed that the key factor in the LHB functioning is the mayor whose perspective counts for or against data based decision making. Before replicating the DDM in other areas, the gains in the pilot areas should first be sustained and the gaps filled up. The role of the RESU has been to monitor but because of their limited manpower and numerous responsibilities its visibility for technical support in data based decision making has to be further heightened.

Recommendations:

1. In recognition of political instability, efforts on upgrading of skills should be concentrated on RESU, PHO, MHO and DOH representatives.
2. Technical skills training should be promotive of cross-functionality so that if somebody is not present or is busy, someone can take over in a temporary capacity if the need arises.
3. The software should be made more user-freindly so that local indicators can be imputed.
4. Local purchase of hardware is recommended to ensure maintenance and preventive care.
5. The local health board, being an advisory body, can be by passed at anytime. The success of DDM should not be gauged on the local health board decisions alone but should also be assessed by looking at records of decisions by the mayor and in the executive committees.
6. Local chief executive is the key target for continuous orientation and exposure to DDM perspective.

General Conclusion:

Data for decision-making is successful because it has been able to impart a way of thinking, a perspective, a culture. This was achieved not merely through provision of technical skills or hardware. The success was due more to the process of getting the people together and working through common exercises. Any changes in culture, however, will have to permeate to the top levels of authority.